

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - STATE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/14/2013
NAME OF PROVIDER OR SUPPLIER BRIDGE AT MONTEAGLE (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 28 SECOND STREET MONTEAGLE, TN 37356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies Based on observations, testing, and records review on 10/14/13, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications.	N 002	Monitoring Measures: The Facility Maintenance Director/Assistant Maintenance Director will audit oxygen concentrators monthly x three months to ensure all oxygen concentrators are properly connected to the appropriate wall outlet; audit power strip connections monthly x three months to ensure no power strips are back to back; and audit all electrical devices monthly x three months to ensure no extension cords are in use.		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE